Attachment A – Authorized Provider Services

ENROLLMENT
EMPLOYMENT-RELATED PERSONAL CARE SERVICES

Provider Name:_____

Effective Date:_____

PROVIDER is authorized to participate in the following services (Mark all that apply):

(X)	Service	*FOR DHCF USE ONLY* MEDICAID PROVIDER TYPE
X	**SERVICE COORDINATION***	46

***** Attachment B, "Special Provisions Agreement" must be completed to become a provider for these services.

Provider is available to provide services in the following counties:
(Please circle all that apply.)

Beaver	**Box Elder**	**Cache**	**Daggett**	**Davis**	**Duchesne**	**Emery**
Garfield	**Grand**	**Iron**	**Juab**	**Kane**	**Millard**	**Morgan**
Piute	**Rich**	**Salt Lake**	**San Juan**	**Sanpete**	**Sevier**	**Summit**
Tooele	**Washington**	**Wayne**	**Weber**			

The undersigned Provider Representative requests enrollment as a provider of Employment-related Personal Care Services services identified in this Attachment.

_____ _____
Signature of Provider Representative *Date*

The Division of Health Care Financing, Long Term Care Bureau, certifies that the above provider meets all qualifications listed in for the covered services authorized in this agreement and assures the contract provider is continuously certified / licensed throughout the period of the agreement. The undersigned Long Term Care Bureau Representative also certifies that the above designated category of service and provider type are accurate.

_____ _____
Signature of Representative *Date*
Division of Health Care Financing, Long Term Care Bureau